Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004686	A. BUILDING: _____ B. WING _____	R 05/15/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON HOUSE	2116 BUTLER RD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on April 2, 2013. Survey date: May 15, 2013 Facility number: 004686 Provider number: 004686 AIM number: N/A Survey team: Virginia Terveer, RN, TC Sue Brooker, RD Angela Strass, RN Julie Call, RN Census bed type: Residential: 20 Total: 20 Census payor type: Private: 20 Total: 20 Sample: 4 Hamilton House was found to be in compliance with 410 IAC 16.2 in regard to the PSR to the State Residential Licensure Survey. Quality review completed on May 16, 2013 by Randy Fry RN.	{R 000}		